Medicare

and YOUR PHYSICIAN'S BILL

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How Medicare pays for physician services and how Medicare determines how much it will pay

U.S. Department of Health and Human Services
Health Care Financing Administration

INTRODUCTION

This leaflet is intended to help you better understand how Medicare pays for physician services and how Medicare determines how much it will pay for those services. It also explains what you may do if you disagree with the amount Medicare pays toward your claim, and what to do if you have reason to believe you were overcharged or you suspect that Medicare was improperly billed by a health care provider. You will also find an explanation of the new law that limits the amount a physician can charge a Medicare beneficiary for covered services. But first, here are some basic facts about Medicare.

THE TWO PARTS OF MEDICARE

Medicare, which provides health insurance to some 35 million Americans, has two parts—Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part A helps pay for inpatient hospital care and certain follow-up care, such as care in a skilled nursing facility. Part B helps pay for physician services and many other medical services and items.

Unless you state that you don't want it, you generally are automatically enrolled in Part B when you are enrolled in Part A. When you are enrolled in Part B, you will be required to pay a monthly premium. The premium, which is subject to change each year, is $31.80 per month in 1992. Although you do not have to purchase Part B, it is an excellent buy because the Federal Government pays about 75 percent of the program costs. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your protection started. If you only have one part of Medicare, you can obtain information from any Social Security Administration office about getting the other part.

Part A and Part B have their own unique systems for paying claims (bills) for covered services and supplies provided to Medicare beneficiaries. Medicare claims and payments are handled by insurance organizations under contract to the Federal Government. The organizations that handle claims from hospitals, skilled nursing facilities, home health agencies, renal dialysis facilities and hospices are called "intermediaries." You almost never have to get involved in the Part A claims process.

Other insurance organizations handle Medicare Part B claims and are called "carriers." There are times when you might want information about the charges appearing on a Part B claim, or about the status of your claim, and you will want to contact the carrier. The names and addresses of the carriers and areas they serve are listed in the back of ***The Medicare Handbook***, which may be obtained from any Social Security Administration office, or by calling 1-800-638-6833.

MEDICARE PART B BENEFITS

Part B helps pay for medically necessary physician services, including surgical services, no matter where you receive them—at home, in the doctor's office, in a clinic or hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the in-home use of durable medical equipment, such as wheelchairs, walkers and hospital beds.

Additionally, Part B covers physical therapy, occupational therapy, and speech pathology services in a doctor's office, in an outpatient setting, or in your home. Mental health services are covered along with blood, mammograms and Pap smears. And if you qualify for home health care but do not have Medicare Part A, then Part B pays for all covered home health visits. Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished hospice enrollees, drugs that you cannot administer yourself that are provided as part of a physician's service, special drugs furnished during the first year after an organ transplantation, and erythropoietin for certain home dialysis patients.

MEDICARE'S APPROVED AMOUNT

Medicare's system for paying physicians is based on a national fee schedule. The schedule, which went into effect January 1, 1992, assigns a dollar value to each physician service based on work, the geographic variation in medical practice costs, and malpractice insurance costs. The fees that appear on the schedule are the Medicare-approved amounts for services covered by Part B. Under the Part B payment system, each time you go to a physician for a covered service, the amount Medicare will recognize for that service will be taken from the national fee schedule.

CHARGES YOU PAY

When you use your Part B benefits, you are responsible for paying the first $100 each calendar year for services and supplies covered by Medicare. This is called the Part B annual deductible. The $100 must be based on the Medicare-approved amounts, not the actual charges billed by your physician if those charges exceed the Medicare-approved amounts.

After you have met the $100 deductible, Medicare starts paying a share of your medical expenses. Part B generally pays 80 percent of the Medicare-approved amount for all covered services you receive the rest of the year. You are responsible for the other 20 percent, which is called coinsurance. You also are responsible for all permissible charges in excess of

the Medicare-approved amount (see panel 6), and for all charges for services and supplies not covered by Medicare.

ASSIGNED & UNASSIGNED CLAIMS

Each time you use the services of a physician, the physician submits your Medicare claim to the carrier either on an "assigned" or "unassigned" basis. When a claim is assigned, it means that the physician has agreed to accept the Medicare-approved amount as payment in full. The physician bills you for 20 percent of the approved amount plus any unmet portion of the Part B deductible. On assigned claims, Medicare pays its share directly to the physician.

When a claim is unassigned, it means that the physician can charge more than the Medicare-approved amount, but not more than the limiting charge. The physician bills you for the full amount and files your claim with the carrier. Medicare then reimburses you its share of the charges. Because you cannot always tell in advance whether the Medicare-approved amount and the actual charge for covered services and supplies will be the same, ask your physicians and medical suppliers whether they accept assignment of Medicare claims.

PARTICIPATING PHYSICIANS & SUPPLIERS

While some physicians and medical suppliers accept assignment on a case-by-case basis or not at all, others sign Medicare participation agreements that require them to accept assignment on all Medicare claims. These physicians and suppliers are called participating physicians and suppliers and their names and addresses are listed in the Medicare Participating Physician/Supplier Directory for your area. The directory is

distributed to senior citizen organizations, all Social Security Administration and Railroad Retirement Board offices, all hospitals, and all State and area offices of the Administration on Aging. The directory may also be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area, or you can call the carrier to find out which doctors and suppliers are Medicare participants.

REQUIRED ASSIGNMENT

There are occasions when health care providers who do not participate in Medicare are required by law to accept assignment of a Medicare claim. For instance, all physicians and qualified laboratories must accept assignment for clinical diagnostic laboratory tests covered by Medicare. Physicians also must accept assignment for covered services provided to beneficiaries who are enrolled in the **Qualified Medicare Beneficiary Program**. These are low-income individuals whose Medicare monthly premiums and at least some of the Medicare deductibles and coinsurance amounts are paid by a State Medicaid program. This assistance is generally available to individuals with annual incomes at or below the Federal poverty level ($6,810 a year in 1992 for an individual who has less than $4,000 in assets, aside from a house and car, and $9,190 for a couple with less than $6,000 in assets). If you think you qualify for this assistance, you should file an application for Medicaid at a State or local office—not a Social Security Administration or other Federal office—that serves people on Medicaid. The income and assets figures are somewhat higher for Alaska and Hawaii.

Medicare law also requires physicians who do not take assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If the physician does not give you a written estimate, you are entitled to a refund of any amount you

paid in excess of the Medicare-approved amount for the surgery.

LIMITS ON PHYSICIAN CHARGES

There is a limit on the amount a physician who does not accept assignment can charge you for Medicare-covered services. In 1992, the most you can be charged is 120 percent of the Medicare fee schedule amount for nonparticipating physicians. In 1993, the limit will be 115 percent. Here's a comparison of your share of the cost for the same service provided by a participating physician and by a nonparticipating physician who did not accept assignment:

If you went to a participating physician for a service for which the fee schedule amount was $100, the physician would accept that amount as payment in full. Medicare would pay $80 and you would be responsible for $20, assuming you had already met the Part B $100 annual deductible.

For the same service furnished by a nonparticipating physician, the fee schedule amount would be $95 (Nonparticipating physicians are reimbursed at 95 percent of the fee schedule amount for participating physicians). Medicare would pay $76, or 80 percent, leaving you with a balance of $19 to cover the remaining 20 percent of the fee schedule amount. However, since nonparticipating physicians who do not accept assignment can legally charge 20 percent more than the fee schedule amount, another $19 could be added to the bill, bringing your out-of-pocket cost to $38, assuming you had already met the Part B deductible. You would not have to pay any charges over $38.

To find out what the limiting charge is for a particular service, you can contact your Medicare carrier. Limiting charge information will also appear on a new "Explanation of Medicare Benefits" (EOMB) form to be introduced in 1992. If

you think your physician has exceeded the charge limit, you may want to first contact the physician and ask for a reduction in the charge. If you cannot satisfactorily settle the issue with the physician, you can call the carrier and request an investigation. If it appears to the carrier that you were overcharged, the carrier will contact the physician and ask for a refund of any overpayments you may have made. Sanctions can be imposed against any physician who knowingly and willfully, and on a repeated basis, charges Medicare beneficiaries more than the legal limit. Besides the charge limitations mandated by Federal law, some States also limit physician charges.

MEDICALLY UNNECESSARY SERVICES

You should also be aware that any physician who provides you with services that he or she knows or believes Medicare will determine to be medically unnecessary and thus will not pay for is required to so notify you in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay. However, if you did receive written notice and signed an agreement to pay for the service yourself, you will he held liable to pay.

MEDICARE PAYMENT NOTICE

Regardless of whether your physicians or medical suppliers accept assignment of a claim, they are required by law to submit the claim for you within a year after providing a service. The claim is submitted to the carrier that serves the area where the covered service or supply was provided, not necessarily the carrier for your State. If for some reason the claim is not filed as required, you can still send it to the carrier as long as you do so before the close of the calendar year following the year in which the service was furnished. If the service was furnished in the last quarter of the year, you have until the close of the second year following the year in which the service was furnished to submit the claim.

After your physician or supplier submits your Part B claim, the Medicare carrier will usually send you an Explanation of Medicare Benefits. It details the action taken on the claim. For services of a physician, this notice shows what services were covered, what charges were approved, how much was credited toward your $100 annual deductible, and the amount Medicare paid. For other Part B services, the notice shows similar information. If you believe payment was made for a service or supply you didn't receive, or the payment is otherwise questionable, you should call or write the carrier that handled your claim.

YOUR RIGHT TO APPEAL

You have a right to challenge Medicare payment decisions with which you disagree. Your Explanation of Medicare Benefits form indicates why your claim was denied or not paid in full, and it also tells you exactly what appeal steps you can take. If you decide to file an appeal, ask your physician or medical provider for any additional information related to the claim that might be helpful to you in challenging the payment decision.

A request for review along with any additional information must be filed with the carrier within six months of the date payment was denied. After the request is filed, the carrier will review the payment decision and provide you with a written explanation of the review determination. If you again disagree and the amount remaining in question is $100 or more, you have six months from the date of the review determination to request a hearing before a carrier hearing officer. If you disagree with the carrier hearing officer's decision and the amount remaining in question is $500 or more, you have 60 days from the date you receive the decision to request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal court.

COORDINATED CARE PLANS

The preceding sections explain how Medicare Part B works if you receive your benefits through the traditional fee-for-service (pay-as-you-go) delivery system. As a Medicare beneficiary, you also have the option of receiving physician and other health care services through coordinated care plans that have contracts with Medicare, such as health maintenance organizations (HMOs), and competitive medical plans (CMPs).

In a coordinated care plan, a network of health care providers (physicians, hospitals, skilled nursing facilities, etc.) generally offers medical services to plan members on a prepaid basis. Services usually must be obtained from the professionals and facilities that are part of the plan. If you enroll in a plan that has a contract with Medicare, a Medicare claim will seldom need to be submitted on your behalf. Medicare pays the plan a set amount and the plan provides your medical care. Additionally, instead of paying Medicare's deductible and coinsurance as you would under fee-for-service care, most coordinated care plans charge enrollees a monthly premium and nominal copayments.

Most plans serving Medicare beneficiaries are required to provide all Medicare hospital and medical benefits available in the plan's service area. Some plans also provide benefits beyond what Medicare pays for, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses. For more information about coordinated care plans request a copy of the leaflet ***Medicare and Coordinated Care Plans*** from any Social Security Administration office or by writing to either: Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, MD 21207; or Consumer Information Center, Pueblo, CO 81009.

WHEN OTHER INSURANCE PAYS BEFORE MEDICARE

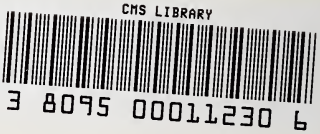
Some people who have Medicare also have group health or other types of coverage which may make Medicare a secondary payer on their health care claims. Medicare is the secondary payer for individuals:

- Who are aged 65 or older and working with coverage under an employer health plan.
- Who are aged 65 or older and who are covered by a working spouse's employer group health plan.
- With coverage under automobile, no-fault, or liability insurance.
- With kidney failure, for up to the first 18 months of Medicare entitlement, if they have coverage under their own employer group health plan (EGHP), or if coverage is provided them because they are the spouse or dependent of an individual with group health plan coverage.
- Who are disabled and qualify as an "active individual," if they have coverage under their own large group health plan (LGHP), or who are disabled and have coverage under the EGHP of an employed family member.

If you fit into one of these categories, your medical and hospital bills are first submitted for payment to the other insurer. Medicare, as the secondary payer, might pay some or all of the charges for services covered by Medicare that are not fully paid by the primary payer.

INSURANCE THAT SUPPLEMENTS MEDICARE

While Medicare pays a large portion of your medical costs, it does not fully pay for all covered services, and there are various services which Medicare does not cover. For this reason, many private insurance companies offer health insurance to supplement Medicare. This insurance, called "Medigap," provides coverage to fill some of the gaps in Medicare and, in some cases, to pay for services and supplies not covered by Medicare. For more information about supplemental insurance, request a copy of the publication titled ***Guide to Health Insurance for People With Medicare*** from one of the sources listed on panel 10.



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